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No. 93-1251

In The

Supreme Court of the United States

October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF OF AMICI CURIAE MOTHER FRANCES HOSPITAL AND OSTEOPATHIC MEDICAL CENTER OF TEXAS IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

Mother Frances Hospital of Tyler, Texas, and Osteopathic Medical Center of Texas (the "Amici Hospitals") both have a direct interest in the outcome of this case, because both currently have lawsuits pending on the advance refunding issue presented by the case at bar.

Mother Frances Hospital is a not-for-profit, religiously affiliated hospital located in Tyler, Texas. Osteopathic Medical Center of Texas is a not-for-profit hospital located in Fort Worth, Texas.

For its fiscal year ending in 1987, Mother Frances Hospital sought Medicare reimbursement for a loss incurred on an advance refunding transaction similar to the one in the case at bar. The hospital sought to be reimbursed for the loss in the year in which the advance refunding occurred. The hospital prevailed before the Provider Reimbursement Review Board ("PRRB"), but that decision was reversed by the Administrator of the Health Care Financing Administration ("HCFA"). *Mother Frances Hospital (Tyler, Tex.)*, PRRB Dec. 92-D11 (Feb. 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,014; *Mother Frances Hospital*, HCFA Admin. Dec. (Mar. 30, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,778. Mother Frances Hospital sought judicial review of the Administrator's decision, culminating in a decision on March 3, 1994, by the United States Court of Appeals for the Fifth Circuit. *Mother Frances Hospital of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994). Mother Frances Hospital prevailed in the Fifth Circuit. The Fifth Circuit's opinion expressly relied upon the decision of the Sixth Circuit in the *Guernsey* case. *Id.* at 427-28. On May 31, 1994, the governmental defendants in the *Mother Frances* case filed a petition for a writ of certiorari with this Court. *Shalala v. Mother Frances Hospital of Tyler, Texas*, No. 93-1907.

Osteopathic Medical Center of Texas also sustained a loss on advance refunding, and sought to recover Medicare reimbursement for such loss for the year in which the transaction occurred. After the hospital prevailed before the PRRB, the Administrator reversed in the *Osteopathic Medical Center* case as well. *Fort Worth Osteopathic Medical Center (Fort Worth, Tex.)*, PRRB Dec. 92-D39 (July 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,413; *Fort Worth Osteopathic Medical Center*, HCFA Admin. Dec. (Sep. 9, 1992), Medicare & Medicaid Guide (CCH) ¶ 40, 870. Osteopathic Medical Center of Texas then brought suit in the Northern District of Texas, seeking reversal of the Administrator's decision. The case is currently pending. *Fort Worth Osteopathic Hospital, Inc. d/b/a Osteopathic Medical Center of Texas v. Shalala*, Civil Action No. 3:CV-92-2337-P (N.D. Tex). The Sixth Circuit in the *Guernsey* case relied in part upon the reasoning of the PRRB's decision in the *Osteopathic Medical Center* case. Pet. App. 12a-13a.

The issues presented by this case have been presented in the *Mother Frances* and *Osteopathic Medical Center* cases. Accordingly, both hospitals have a direct stake in the outcome of this litigation and, in accordance with the letters of consent of both parties being filed herewith, respectfully submit this Brief of Amici Curiae.

SUMMARY OF ARGUMENT

The Amici Hospitals will not address whether 42 C.F.R. §§ 413.20(a) and 413.24 require Medicare reimbursement in this case to be determined in accordance with generally accepted accounting principles ("GAAP"). Instead, this brief addresses issues under the Administrative Procedure Act ("APA") concerning whether PRM § 233 is a "substantive" rule, "interpretative" rule, or "general statement of policy" under the APA, and

whether the Administrator's decision is in accordance with APA standards for review of agency decisions.

Under the APA and prevailing case law, PRM § 233 is a "substantive" rule. It creates the law relating to losses on advance refunding, specifies the obligations of hospitals in detail, and has been enforced by the Secretary in a binding manner. Furthermore, PRM § 233 changes the reimbursement rules previously applied by the Secretary to losses on advance refundings. It is a change from PRM §§ 215 and 215.1, which preceded PRM § 233. It also is a change from a rule of decision that looked to GAAP requirements which was applied by the Secretary to advance refundings prior to the existence of any Medicare manual provisions on this subject. Certainly, it represents a change from the GAAP requirement imposed by 42 C.F.R. §§ 413.20(a) and 413.24, but even if those regulations did not exist, PRM § 233 is a change from the rules previously applied in fact by the Secretary.

PRM § 233 is not an "interpretative" rule, as the Secretary contends. There is no regulation that addresses advance refundings or cognate issues. The only regulation quoted by the Administrator in his decision, of which he claimed PRM § 233 to be interpretative, is 42 C.F.R. § 413.9(b)(1). That regulation, however, only addresses retroactive adjustments, a subject unrelated to PRM § 233. The other four regulations now cited by the Secretary in her brief were not relied upon by the Administrator in his decision, were not argued before the Sixth Circuit, and do not provide any support for PRM § 233.

Similarly, the Secretary's contention that PRM § 233 is a "general statement of policy" is erroneous. PRM § 233 has been applied in a binding fashion by the Secretary, and cannot be considered as a statement of the agency's

"tentative intentions for the future." If, *arguendo*, PRM § 233 were to be considered a general statement of policy, it could not provide any support for the Administrator's decision. In order to stand, that decision must be supported by the administrative record as if PRM § 233 had never been issued. However, the administrative record in this case does not provide substantial evidence to support the Administrator's decision.

The decision of the Sixth Circuit should therefore be affirmed.

ARGUMENT

The parties in this case have presented two issues for review, although they phrase them somewhat differently.

The first issue is whether the regulations codified at 42 C.F.R. §§ 413.20(a) and 413.24 require Medicare reimbursement for losses on advance refundings to be determined in accordance with GAAP instead of in accordance with PRM § 233, a Medicare manual provision.

The second issue is whether PRM § 233 constitutes a "substantive" or "legislative" rule under the APA, and is thus invalid due to the failure of the Secretary to promulgate it as a regulation by publishing it in the *Federal Register* after notice and an opportunity for public comment.

The Amici Hospitals strongly agree that 42 C.F.R. §§ 413.20(a) and 413.24 require GAAP to be followed in making Medicare reimbursement determinations under the circumstances of this case. However, that issue will not be addressed in this brief.

Instead, this brief will focus on APA issues related to the rulemaking argument, in a broader context than the parties have been able to address. Particularly, the Amici Hospitals will demonstrate that the Secretary's arguments, if accepted, would permit her to evade the APA's rulemaking requirements and its requirements that administrative decisions be based on the record created at the hearing.

I. THE ADMINISTRATOR'S DECISION MUST BE REVERSED BECAUSE IT IS FOUNDED ON PRM § 233, WHICH IS A SUBSTANTIVE RULE PROMULGATED WITHOUT NOTICE AND COMMENT UNDER THE APA

A. The APA requires notice and comment rulemaking for substantive rules such as PRM § 233.

The APA requires notice of proposed rulemaking to be published in the Federal Register, and the notice must contain certain specified information. 5 U.S.C. § 553(b). The agency is required to give interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without the opportunity for oral presentation. 5 U.S.C. §§ 553(c), 553(d). After consideration of the relevant matter presented, "the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose." 5 U.S.C. § 553(c). The statement of basis and purpose is meant, amother things, "to facilitate meaningful judicial review. The agency's statement must be sufficiently detailed and informative to permit a reviewing court to determine how and why the rules were actually adopted." 3 J. Stein, G. Mitchell, and B. Mezines, *Administrative Law* § 15.09, at 15-164, 15-165 (rev. ed. 1994).

A narrow exception to the notice and comment requirement exists for "interpretative" rules. 5 U.S.C.

§ 553(b)(A). "Interpretative" rules, as opposed to "legislative" or "substantive" rules, are those "which merely clarify or explain existing law or regulations," *Alcaraz v. Block*, 746 F.2d 593, 613 (9th Cir. 1984), *quoting Powderly v. Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983). "An agency rule that reminds parties of existing statutory duties is also considered interpretative, not legislative." *National Family Planning and Reproductive Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 236 (D.C. Cir. 1992). The exception for interpretative rules to the APA's notice and comment rulemaking requirements is "narrowly construed and only reluctantly countenanced." *Alcaraz*, 746 F.2d at 612, *quoting American Federation of Government Employees v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981).

The Secretary agrees that a rule is "substantive" if it "impose[es] a new substantive obligation." Pet. Br. at 38 n.23, *citing McCown v. Secretary of HHS*, 796 F.2d 151, 157 (6th Cir. 1986), *cert. denied*, 479 U.S. 1037 (1987). Another test cited by the Secretary is that a rule is "substantive" if it creates "new law, rights, or duties." *Id.*, *citing Friedrich v. Secretary of HHS*, 894 F.2d 829, 834 (6th Cir.), *cert. denied*, 498 U.S. 817 (1990) (*quoting General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 D.C. Cir. 1984) (en banc), *cert. denied*, 471 U.S. 1074 (1985)). Many courts of appeals have defined substantive rules as those which "grant rights, impose obligations, or produce other significant effects on private interests."[1] Substantive rules have also been characterized as " 'those which effect a change in

[1] *See, e.g., National Family Planning and Reproductive Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 238 (D.C. Cir. 1992); *Perales v. Sullivan*, 948 F.2d 1348, 1354 (2d Cir. 1991); *American Ambulance Service v. Sullivan*, 911 F.2d 901, 907 (3d Cir. 1990); *Avoyelles Sportsmen's League, Inc. v. Marsh*, 715 F.2d 897, 908 (5th Cir. 1983); *Ohio Dep't of Human Services v. United States Dep't of Health and Human Services*, 862 F.2d 1228, 1233 (6th Cir. 1988); *Zaharakis v. Heckler*, 744 F.2d 711, 713 (9th Cir. 1984).

existing law or policy,' or remove previously existing rights." *Linoz v. Heckler*, 800 F.2d 871, 877 (9th Cir. 1986) *quoting Powderly*, 704 F.2d at 1098.[2]

B. PRM § 233 is a substantive rule.

Under the tests stated above, PRM § 233 is a substantive rule that was not promulgated through rulemaking, and is therefore invalid.

First, PRM § 233 "creates new law, rights or duties," and "grant[s] rights, impose[s] obligations, or produce[s] other significant effects on private interests."

Instead of being interpretative of a regulation, PRM § 233 creates out of whole cloth a detailed set of payment rules governing advance refundings. If one examined only the Medicare statutes and regulations, one would have not the slightest clue as to how payment for advance refundings would be treated (unless GAAP were followed pursuant to 42 C.F.R. § 413.20(a)). PRM § 233 does

[2] Apart from the APA, there is also a specific Medicare statute that specifies when the Secretary must proceed by rulemaking. The statute provides that "No rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . under this subchapter shall take effect unless it is promulgated by the Secretary by regulation . . . . " 42 U.S.C. § 1395hh(a)(2). Although this specific language was added to the statute after the effective date of PRM § 233, it is instructive that Congress has now also manifested its understanding that provisions such as PRM § 233 that "establish or change" a "substantive legal standard" governing "the payment for services" are the types of substantive rules that are ineffective unless they are promulgated by regulation, as the case law and APA already provided.

not "elaborate on what is already contained in the regulations," as the Secretary contends. Pet. Br. at 40. Instead, it is being used as a substitute for or supplement to the regulations and statutes. As a recent D.C. Circuit case stated: "[A] rule is legislative if it attempts 'to supplement [a statute], not simply to construe it.' " *National Family Planning*, 979 F.2d at 237 (*quoting Chamber of Commerce v. OSHA*, 636 F.2d 464, 469 (D.C. Cir. 1980)). PRM § 233 creates "new law" regarding advance refundings. PRM § 233 imposes on providers an "obligation" or a "duty" to defer receipt of Medicare reimbursement into future years. That obligation is not discernable or even hinted at anywhere in the Medicare regulations. Unquestionably, PRM § 233 also "establishes" a "substantive legal standard" governing "the payment for services." 42 U.S.C. § 1395hh(a)(2). Under PRM § 233, the standard for payment is set forth explicitly, and that standard requires payment to be amortized over future periods.[3]

Second, PRM § 233 "effect[s] a change in existing law or policy" governing reimbu[illegible]ement for advance refunding losses, *Linoz*, 800 F.2d at 877, and "changes a substantive legal standard" governing "payment for services." 42 U.S.C. § 1395hh(a)(2).

HCFA originally had no written rule or manual provision expressly governing treatment of losses on advance refundings. Instead HCFA followed GAAP in

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[3] Although the Secretary characterizes PRM § 233 as not having "the force and effect of law" as do substantive rules, Pet. Br. at 37, and refers to it as only an "informal guideline," *id.*, it has been applied by the Secretary as a binding rule. *See* Part III, below.

determining how losses from refunding transactions should be reimbursed. In *Washoe Medical Center*, PRRB Dec. 81-D51 (May 27, 1981), Medicare & Medicaid Guide (CCH) ¶ 31,074, the advance refunding had taken place in 1972, prior to the effective date of APB No. 26. As permitted under GAAP in 1972, the provider elected to amortize the loss. After the effective date of APB No. 26, the provider attempted to take the balance of the loss in a single year, as APB No. 26 prescribed. HCFA refused to allow the provider to do so, on grounds that GAAP must be followed and that the loss had occurred prior to the effective date of APB No. 26. The decision of the PRRB states:

> The Board finds that the balance of the unamortized loss claimed by the provider on the advance refunding of its bonds is not allowable in 1978. The provider's amortization of this loss was an acceptable method of reporting the loss under generally accepted accounting principles in effect during 1972, the year of the advance refunding, and under section 212.1 of the PRM. *The APB Opinion No. 26*, as amended (APB No. 26) cited by the provider as authority to write off the unamortized loss in 1978 *is effective for all extinguishments of debt occurring on or after January 1, 1973*. Since the provider's loss on advance refunding occurred during fiscal year ending June 30, 1972, that Opinion is not applicable. (emphasis added)

Id., ¶ 31,074 at 10,338. It is clear from this passage that the PRRB looked to GAAP as providing the binding rule of decision for treatment of a loss on advance refunding. The *Washoe* decision was not reversed or modified by the Administrator, and so is final, official action by the Secretary.

Next, HCFA issued PRM §§ 215 and 215.1. Medicare & Medicaid Guide (CCH) ¶¶ 5007, 5008. In a series of decisions later reversed by the courts, the Administrator interpreted PRM §§ 215 and 215.1 to apply to advance refundings. *See Baptist Hospital East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Mercy Hospital v. Sullivan*, No. 90-0024-P (D.Me. 1991), Medicare & Medicaid Guide (CCH) ¶ 40,227; *Ravenswood Hospital Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985). Amortization of losses over future years was required under §§ 215 and 215.1 only for "big losses" amounting to 50% or more of the cost that would have been incurred during the year. "Small losses," amounting to less than 50% of the cost that would have been incurred in that year, were reimbursed in full in the year in which they were incurred. Unlike losses, PRM §§ 215 and 215.1 required gains on advance refunding to be taken in their entirety in the year in which they were incurred. *Ravenswood*, 622 F.Supp. at 344-45.

PRM § 233, by contrast, does not provide for differential treatment between larger and smaller losses, based on the 50% limit that was provided by PRM §§ 215 and 215.1. PRM § 233 also changed the rule in PRM §§ 215 and 215.1 that required gains to be recognized currently, instead of treating gains in the same manner as losses, as PRM § 233 requires.

As shown above, HCFA has had at least three different substantive policies regarding treatment of losses on advance refunding: 1) following GAAP, as in the *Washoe* case; 2) PRM §§ 215 and 215.1; and 3) PRM § 233. Thus, § 233 does not merely "elaborate on what is already contained in the regulations." Pet. Br. at 40. There is no regulation regarding treatment of losses on advance

refunding. Instead, PRM § 233 is a substantive rule that changes previously existing law or regulations. *Linoz*, 800 F.2d at 877.

C. The rulemaking argument is logically independent of any finding as to whether 42 C.F.R. § 413.20(a) requires GAAP to be followed in this case.

The Secretary argues that the conclusion by the Sixth Circuit that PRM § 233 is a "substantive" rule "has no force independent of the court's determination that the Manual provision, which was issued without formal notice or comment, [footnote omitted] conflicts with what the court perceived to be a GAAP-based reimbursement requirement embodied in Sections 413.20 and 413.24 of the regulations." Pet. Br. at 36. A similar statement appears at page 17 of the Petitioner's Brief.

The Secretary misconceives the nature of the rulemaking argument. The rulemaking argument in this case is logically independent of the argument that the GAAP and accrual accounting regulations require reimbursement for a loss on advance refunding in the year in which the loss is incurred. If, as the Sixth Circuit found, 42 C.F.R. § 413.20 requires GAAP to be followed in determining reimbursement, it is certainly true that PRM § 233 represents a change from the requirement of that binding regulation (indeed, flatly contradicts it) and is thus a substantive rule.

However, it does not follow that PRM § 233 is necessarily "interpretative" and not "substantive" if it were to be found that 42 C.F.R. §§ 413.20 and 413.24 do not require GAAP to be followed. Had those regulations

never existed, PRM § 233 would still "create law" regarding treatment of advanced refundings, and "impose obligations" on providers to defer the loss to future years. Furthermore, as demonstrated above, PRM § 233 represents a change in fact from the previous standards employed by Medicare in determining treatment of a loss on advanced refunding. It represents a change from PRM §§ 215 and 215.1, which in turn represented a change from the GAAP rule applied by the Secretary in the *Washoe* case.

Thus, PRM § 233 meets the definition of a "substantive" rule under the APA and relevant case law, even if it does not conflict with §§ 413.20 and 413.24. The Sixth Circuit did not need to reach the issue of whether PRM § 233 is a substantive rule independently of its conflict with 42 C.F.R. §§ 413.20 and 413.24. That is because the Sixth Circuit found that PRM § 233 does conflict with those binding regulations. However, both the Amici Hospitals explicitly argued in their cases in the District Courts, and Mother Frances Hospital argued in the Fifth Circuit, that PRM § 233 is a substantive rule under a straightforward APA analysis, without reference to whether it conflicts with the GAAP requirement imposed by 42 C.F.R. §§ 413.20(a) and 413.24. PRM § 233 is thus invalid not only because it conflicts with 42 C.F.R. §§ 413.20(a) and 413.24, but also because it is a substantive rule even if there were no such conflict.

II. PRM § 233 IS NOT AN INTERPRETATIVE RULE

In his decision, the only regulation of which the Administrator claimed PRM § 233 was interpretative was

42 C.F.R. § 413.9(b)(1).[4] The Secretary's argument that PRM § 233 is interpretive of 42 C.F.R. § 413.9(b)(1) relies upon selective quotation of that regulation out of context. The Administrator's decision asserts that 42 C.F.R. § 413.9(b)(1) "requires payments to be based on 'the actual cost of services rendered to beneficiaries during the year.' " Pet. App. at 47a. A reading of § 413.9(b)(1) in context reveals that the portion quoted is merely introductory in nature, and describes the effect of specific regulations that follow it in the Code of Federal Regulations. The full text of the last two sentences of 42 C.F.R. § 413.9(b)(1), in which the portion quoted by the Administrator appears, is as follows:

> These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

As can be seen, the phrase quoted out of context does not deal with advance refundings, or even with any general principle pertaining to attribution of costs to proper years. Instead, it explains the provisions of subsequent

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[4] Pet. App. at 47a. The Administrator cited the regulation as 42 C.F.R. § 405.451, and noted in a footnote that it has been recodified at 42 C.F.R. § 413.9. However, the only language from that regulation quoted by the Administrator in his decision is the phrase "the actual cost of services furnished to beneficiaries during the year," which is now codified as 42 C.F.R. § 413.9(b)(1).

regulations which specify that Medicare will make retroactive adjustments at the end of the cost year to reconcile the difference between the estimated payments made on an interim basis by Medicare during a single cost year, and the costs that are finally determined after the yearly cost report is filed. The mechanics of these retroactive adjustments – which have nothing to do with the issues in this case – are treated by 42 C.F.R. §§ 413.60 and 413.64.

The reference to "accepted methods of cost apportionment" in 42 C.F.R. § 413.9(b)(1), it should be noted, does not refer to any method for apportioning costs *among years*. "Methods of cost apportionment" is a term of art under Medicare. Such methods include the "departmental method," the "carve out method," and the "cost per visit method." *See* 42 C.F.R. § 413.53; *see also* 42 C.F.R. § 413.56. Use of a particular method of cost apportionment also has no bearing on the issues in this case.

Thus, the *only* reason why the phrase "during the year" appears in 42 C.F.R. § 413.9(b)(1) is to summarize the subsequent regulations dealing with retroactive adjustments. Those retroactive adjustments are used simply to reconcile estimated, interim payments for a given cost reporting year with the payment finally determined after the filing of the cost report. The Secretary's artful quotations from the regulations, Pet. Br. at 31 – which are apparently designed to imply that the "cost apportionment" and "cost finding" methods relate to allocations *among years* (which they do not) – should not be allowed to obscure the fact that these regulations deal with the mechanics of interim payment and reconciliation, not with issues bearing on this case. PRM § 233 sets forth detailed rules on losses from advance refundings, and

cannot reasonably be held to be interpretative of a regulation dealing with retroactive adjustments, which is a completely separate subject.

42 C.F.R. § 413.9(b)(1) is plainly inapplicable to advance refundings, and no court case has sustained PRM § 233 as "interpretative" of that regulation. Therefore, the Secretary has in her recent appellate arguments, in the Fifth Circuit and in this Court, attempted to add or substitute different regulations of which she now claims PRM § 233 is interpretative.

Apart from 42 C.F.R. § 413.9(b)(1), the Secretary now newly cites four regulations or groups of regulations which she claims "provide ample 'legislative authority' for reimbursement of bond issuance costs incurred by providers and the allocation of such reimbursement to particular periods . . . ."[5] Pet. Br. at 39. The Amici Hospitals will consider these four regulations in order.

First, the Secretary argues that the "regulations authorize reimbursement of 'capital related costs' that are 'appropriate and helpful in . . . maintaining the operation of patient care facilities.' " *Id.* She cites 42 C.F.R. § 413.9(b)(2) for this proposition, with a "see generally" citation to 42 C.F.R §§ 413.130-413.157. But 42 C.F.R. § 413.9(b)(2) does not even mention "capital-related costs." It is simply a definition of "necessary and proper costs," a term used elsewhere in the regulations. The "see

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[5] The Secretary repeatedly refers to "bond-issuance costs" as being at stake in this case. Pet. Br. at 39. The Court should be aware that it is not "bond-issuance costs," which arise upon the issuance of new debt, that are at issue here, but rather a loss on the defeasance of the old bonds. "Debt issuance costs," by the admission of the Intermediary's own witness, are not part of the controversy over the loss. Admin. Rec. 347 (Andrews).

generally" citation to 42 C.F.R. §§ 413.130-413.157 adds nothing to the analysis. That citation is to the entirety of "Subpart G – Capital-Related Costs" of the Medicare regulations. It is not disputed that capital-related costs are reimbursable. The Secretary points to no specific regulation contained in Subpart G of which PRM § 233 is allegedly interpretative, except as noted below.

Second, the Secretary cites 42 C.F.R. §§ 413.130(a)(7) and (g) from Subpart G. Pet. Br. at 39. This citation is extraordinary in several respects. In the *Mother Frances* case, the Secretary adopted a similar approach, citing on appeal numerous regulations that had not been relied upon by the Administrator. The only portion of 42 C.F.R. § 413.130 cited by the Secretary in *Mother Frances* was § 413.130(a)(10), treating "debt issuance costs." In that case, Mother Frances Hospital pointed out that the costs at issue are not "debt issuance costs" but costs associated with early extinguishment of existing debt.[6] Furthermore, 42 C.F.R. § 413.130(a)(10) was not promulgated until more than eight years after PRM § 233 became effective. 56 Fed. Reg. 43358, 43456 (Aug. 30, 1991).

The Secretary apparently now no longer contends that PRM § 233 is "interpretative" of a regulation promulgated more than eight years after PRM § 233 was issued. Instead, the Secretary has now plucked out two new subsections of 42 C.F.R. § 413.130, and tries to rely upon those subsections instead of § 413.130(a)(10).

Reliance on those two subsections – §§ 413.130(a)(7) and (g) – is similarly unavailing. The subsections relied upon were also published after PRM § 233 was issued.

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[6] Similarly, "debt issuance costs" are not at stake in the case at bar. *See* n. 5, above.

PRM § 233 was adopted by Transmittal No. 288, dated May 1983. 1 Medicare & Medicaid Guide (CCH) ¶ 5182. By its terms, it is "effective for all refundings initiated on or after July 1, 1983." PRM § 233.1, Pet. App. 85a. §§ 413.130(a)(7) and (g) were not published as an interim final rule until September 1, 1983, two months *after* the effective date of PRM § 233. *See* 48 Fed. Reg. 39752, 39809, 39810 (Sept. 1, 1983). It is difficult to accept that PRM § 233 is "interpretative" of regulations that were not yet in existence when it was issued.

Substantively, §§ 413.130(a)(7) and (g) add nothing to the analysis in this case. The combined effect of those two regulations is simply to state that interest expense for acquiring land and/or depreciable assets, or for refinancing existing debt used to acquire land and/or depreciable assets, is categorized as a capital-related expense. 42 C.F.R. § 413.130 was promulgated in 1983, as the Medicare "prospective payment system" or "PPS" was going into effect. Thus, a regulation was needed to distinguish which costs are capital-related costs (and thus not covered under PPS) and which costs are not capital-related costs (which thus may be covered under PPS). That is the purpose of 42 C.F.R. § 413.130.

Third, the Secretary cites 42 C.F.R. §§ 413.153(a)(1) and (b)(1). Pet. Br. at 39. These regulations merely confirm that "necessary and proper" interest is an allowable cost, state that certain types of interest are not an allowable cost, and define "interest." They say nothing about bond defeasances or advance refundings, none of the definitions therein affect the issues in this case, and the Administrator's decision did not claim that PRM § 233 was interpretative of these regulations.

Fourth, the Secretary cites 42 C.F.R. §§ 413.5(a) and 413.9, with a "see" reference to 42 U.S.C. § 1395x(v)(1)(A)(i). Pet. Br. at 39. These regulations are cited for the proposition that "allowable costs be related to beneficiary care." *Id.* There is no contention in this case that the costs at issue are not related to beneficiary care or patient care, as it is more often phrased. If they were not related to patient care they would not be reimbursable. *See* 42 C.F.R. § 413.9(c)(3) ("amounts not related to patient care" are not "allowable," that is, are not reimbursable costs). But the Secretary in this case has admitted that the costs at issue are reimbursable, so the citation to these regulations is irrelevant.

Defendants' attempt to substitute the four regulations discussed above, besides being wholly unpersuasive, is a classic "*post hoc* rationalization" of counsel. *Motor Vehicles Manufacturers Ass'n of the United States v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 50 (1983) ("[T]he courts may not accept appellate counsel's *post hoc* rationalizations for agency action. . . . It is well established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself").

The statutory provision governing reimbursement under this situation is the extraordinarily broad language of 42 U.S.C. § 1395x(v)(1)(A), requiring the Secretary to reimburse hospitals for their "reasonable costs." The Secretary has promulgated a number of regulations to outline what "reasonable costs" means in specific contexts, and the manner in which reimbursement will be made for those costs. But, as shown above, on the subject of the case at bar the regulations are utterly silent. The Secretary should not be permitted to leap from the bare language of

the statute saying "reasonable costs" should be reimbursed, to the kind of minutely detailed rules contained in PRM § 233, while skipping altogether the issuance of regulations. A decision that she may do so would vitiate the Secretary's obligation under the APA to comply with rulemaking requirements in the entire area of Medicare reasonable cost reimbursement to hospitals and other providers.

III. PRM § 233 IS NOT A GENERAL STATEMENT OF POLICY

The Secretary contends that PRM § 233 should be considered a "general statement of policy" under the APA. Pet. Br. at 38; 5 U.S.C. § 553(b)(A). Quite plainly, this is not the case. In an often cited decision, the D.C. Circuit defined general statements of policy as follows:

> A general statement of policy, on the other hand, does not establish a "binding norm." It is not finally determinative of the issues or rights to which it is addressed. The agency cannot apply or rely upon a general statement of policy as law because a general statement of policy only announces what the agency *seeks to establish* as policy. A policy statement announces the agency's *tentative intentions* for the future. *When the agency applies the policy in a particular situation, it must be prepared to support the policy just as if the policy statement had never been issued.* (footnote omitted). An agency cannot escape its responsibility to present evidence and reasoning supporting its substantive rules by announcing binding precedent in the form of a general statement of policy.

Pacific Gas & Electric Co. v. Federal Power Commission, 506 F.2d 33, 38-39 (D.C. Cir. 1974). (emphasis added)

The D.C. Circuit has also recognized that the determination of whether an agency pronouncement is a "general statement of policy," or is in fact a "substantive rule," rests upon whether the agency in its actual course of conduct treats the pronouncement as binding. Some of these cases were summarized in *Public Citizen, Inc. v. Nuclear Regulatory Commission*, 940 F.2d 679, 682-83 (D.C. Cir. 1991):

> [C]ases concerned with the policy statement/substantive rule distinction confirm that the agency's application of a disputed rule is crucial. See *Community Nutrition Inst. v. Young*, 818 F.2d 943, 949 (D.C. Cir. 1987) (notice-and-comment procedures required where the FDA, "by virtue of its own course of conduct", had given action levels a "present binding effect"); *Batterton v. Marshall*, 648 F.2d 694, 706 (D.C. Cir. 1980) (agency's course of conduct revealed that methodology was not merely a policy statement); *see also Vietnam Veterans v. Secretary of the Navy*, 843 F.2d 528, 539 (D.C. Cir. 1988) (agency application of a document in a flexible manner supports classification as a policy statement) [further citations omitted].

The D.C. Circuit in *Public Citizen* went on to note that even a policy that might initially be thought to be a general statement of policy might later be recategorized "based on actual applications of the policy . . . . " *Id.* at 683. Indeed, "a policy initially classed as a general statement [of policy] is not immunized from subsequent judicial review for conformity with the APA if later developments show the agency to be using it as binding policy." *Id.* (*quoting American Hospital Ass'n v. Bowen*, 834 F.2d 1037, 1057 n.4 (D.C. Cir. 1987)).

Although the Secretary attempts to characterize PRM § 233 as a "general statement of policy," the Secretary has

clearly given it binding effect in practice. In at least twelve cases, the PRRB after hearing record evidence attempted to depart from PRM § 233's rule requiring amortization.[7] In each instance, the Administrator reversed the PRRB.[8] Furthermore, the Intermediary's own

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[7] *University of Michigan Hospitals (Ann Arbor, Mich.)*, PRRB Dec. 93-D96 (Sept. 23, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,743; *St. Mary's Regional Medical Center (Reno, Nev.)*, PRRB Dec. 93-D53 (July 1, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,583; *Grant Medical Center (Columbus, Ohio)*, PRRB Dec. 93-D3 (Nov. 27, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,941; *Lourdes Hospital Group*, PRRB Dec. 92-D57 (Sept. 3, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,837; *Fort Worth Osteopathic Medical Center (Fort Worth, Tex.)*, PRRB Dec. 92-D39 (July 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,413; *Michigan Osteopathic Medical Center* (Detroit, Mich.), PRRB Dec. 92-D36 (June 18, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,369; *Henry County Memorial Hospital (New Castle, Ind.)*, PRRB Dec. 92-D26 (Mar. 25, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,171; *Dominican Santa Cruz Hospital (Santa Cruz, Cal.)*, PRRB Dec. 92-D23 (Mar. 6, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,120; *Mother Frances Hospital (Tyler, Tex.)*, PRRB Dec. 92-D11 (Feb. 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,014; *Graham Hospital Association (Canton, Ill.)*, PRRB Dec. 91-D87 (Sept. 30, 1991), Medicare & Medicaid Guide (CCH) ¶ 39,698; *St. Johns Regional Medical Center Group Appeal*, PRRB Dec. 91-D76 (Sept. 6, 1991), Medicare & Medicaid Guide (CCH) ¶ 39,789; *Guernsey Memoriai Hospital (Cambridge, Ohio)*, PRRB Dec. 90-D50 (Aug. 16, 1990), Medicare & Medicaid Guide (CCH) ¶ 38,908.

[8] *University of Michigan Hospitals*, HCFA Admin. Dec. (Nov. 19, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,954; *St. Mary's Regional Medical Center*, HCFA Admin. Dec. (Aug. 30, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,764; *Grant Medical Center*, HCFA Admin. Dec. (Jan. 6, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,079; *Bond Defeasance Group*, HCFA Admin. Dec. (Oct. 27, 1992), Medicare & Medicaid Guide (CCH) ¶ 41,060; *Fort Worth Osteopathic Medical Center*, HCFA Admin. Dec. (Sept. 9, 1992), Medicare & Medicaid Guide (CCH)

witness in this case testified that PRM § 233 is binding on the Intermediary. Admin. Rec. 357.

Thus, PRM § 233 cannot realistically be regarded as announcing "the agency's tentative intentions for the future." PRM § 233 explicitly states that it is "effective for all refundings initiated on or after July 1, 1983." Pet. App. 85a. Furthermore, PRM § 233 essentially codified, with some significant changes, a previously enforced administrative rule requiring amortization of advance refunding losses under PRM §§ 215 and 215.1.

PRM § 233 sets forth detailed payment rules that have been enforced without exception by the Secretary in a binding manner. PRM § 233 is a substantive rule, not a general statement of policy.

IV. THE SECRETARY HAS NOT SUPPORTED PRM § 233, WHICH SHE CONTENDS IS NON-BINDING, BY SUBSTANTIAL EVIDENCE

As noted in *Pacific Gas & Electric*, 506 F.2d at 38, if a pronouncement is a "general statement of policy" it has no binding effect and "[w]hen the agency applies the

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¶ 40,870; *Michigan Osteopathic Medical Center*, HCFA Admin. Dec. (Aug. 14, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,836; *Henry County Memorial Hospital*, HCFA Admin. Dec. (May 22, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,746; *Dominican Santa Cruz Hospital*, HCFA Admin. Dec. (May 5, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,749; *Mother Frances Hospital*, HCFA Admin. Dec. (Mar. 30, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,778; *Graham Hospital Association*, HCFA Admin. Dec. (Nov. 27, 1991); *St. Johns Regional Medical Center Group Appeal*, HCFA Admin. Dec. (Nov. 8, 1991), Medicare & Medicaid Guide (CCH) ¶ 39,792; *Guernsey Hospital*, HCFA Admin. Dec. (Dec. 12, 1990), Medicare & Medicaid Guide (CCH) ¶ 38,910.

policy in a particular situation it must be prepared to support the policy just as if the policy statement had never been issued."

Assuming *arguendo* that PRM § 233 is not a substantive rule and is non-binding, is the Administrator's decision supported just as if PRM § 233 "had never been issued"?

Clearly, it is not. The Secretary, in quoting the APA test for review of agency action, repeatedly quotes only the requirement that agency action not be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." Pet. Br. at 37. But the specific test set forth in the APA for review of agency decisions such as the one at bar is that such decisions must be reversed if they are "unsupported by substantial evidence in a case . . . reviewed on the record of an agency hearing provided by statute." 5 U.S.C. § 706(2)(E). In this case such a hearing was provided by statute. The hearing before the PRRB, with further review by the Administrator, is provided by 42 U.S.C. §§ 1395oo(a); *see also* 42 U.S.C. § 1395oo(f). The Medicare statutes expressly provide that the decision of the PRRB "shall be based upon the record made at such hearing," and "shall be supported by substantial evidence when the record is viewed as a whole." 42 U.S.C. § 1395oo(d). Judicial review, by statute, is made "pursuant to the applicable provisions under Chapter 7 of title 5," that is, pursuant to the APA, including 5 U.S.C. § 706. 42 U.S.C. § 1395oo(f).

As this Court has held, an agency must "articulate [a] rational connection between the facts found and the choice made . . . . " *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962); *Motor Vehicles Manufacturers Ass'n*, 463 U.S. at 43. An agency order must "be

upheld, if at all, on the same basis articulated in the order by the agency itself." *Burlington Truck Lines*, 371 U.S. at 168-69; *see also Biloxi Regional Medical Center v. Bowen*, 835 F.2d 345, 351 n.18 (D.C. Cir. 1987) (if PRRB did not itself rely on a particular factor, "it cannot properly be urged in support of the PRRB's decision").

Agency action will be invalidated if the agency "offer[s] an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicles Manufacturers Ass'n*, 463 U.S. at 43.

Defendants' argument that this Court should give deference to the Secretary's actions due in part to her "significant expertise," Pet. Br. at 29, ignores the fundamental administrative law principle that "[a]gency expertise is not . . . a substitute for evidence in the record." 5 J. Stein, G. Mitchell, and B. Mezines, *Administrative Law* § 51.02, at 51-86 to 51-88 (rev. ed. 1994). The Supreme Court in *Baltimore & Ohio Railroad Co. v. Aberdeen & Rockfish Railroad Co.*, 393 U.S. 87, 91-92 (1968), declared:

> We agree with the District Court that there is no substantial evidence that territorial average costs are necessarily the same as the comparative costs incurred in handling North-South freight traffic. If we were to reverse the District Court, we would in effect be saying that the expertise of the [Interstate Commerce] Commission is so great that when it says that average territorial costs fairly represent the costs of North-South traffic, the controversy is at an end, even though the record does not reveal what the nature of that North-South traffic is. *The requirement for administrative decisions based on substantial evidence and reasoned findings – which alone make effective judicial review possible – would become lost in the haze of so-called expertise. Administrative expertise would then be on its way to*

> *becoming 'a monster which rules with no practical limits on its discretion'. . . . That is impermissible under the Administrative Procedure Act.* (emphasis added)

The Administrator's purported justification for the amortization rule adopted in PRM § 233, and applied in his decision in this case, runs counter to the administrative record. According to the Administrator's decision, PRM § 233 "reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries," Pet. App. 47a, and "the loss is a cost of rendering patient care over several years." *Id.* at 49a. Because the loss was found by the Administrator to relate to rendering patient care over future periods, PRM § 233 allegedly protects the program against "cross-subsidization" of non-Medicare patients by the government if Medicare utilization should decrease or if providers should "drop out of the Program before services are rendered to Medicare beneficiaries in those future years." *Id.*

The key passage in the Administrator's decision is as follows:

> The loss is a cost of rendering patient care over several years. By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization . . . . Further, the program is protected from making a payment attributable to future years and then having the provider drop out of the Program before services are rendered to Medicare beneficiaries in those future years.

Id.

The linchpin of the Administrator's decision is, therefore, the contention that the loss is for future periods, after the year in which the defeasance occurred.

The Administrator's cross-subsidization argument depends upon that factual finding, since the cross-subsidization argument has force, if at all, only if hospitals that have engaged in advance refundings were to drop out of the Medicare program, or have decreasing Medicare utilization, in those future years to which the costs allegedly related.

The administrative record, however, clearly demonstrates that the loss on defeasance is not a cost incurred by the provider in future years.

Under its governing statute, the Medicare program reimburses providers only for costs "actually incurred." 42 U.S.C. § 1395x(v)(1)(A). The testimony of both the provider's expert witness, and the Medicare intermediary's witness, established that after the year of the advance refunding transaction the provider is no longer liable for repayment of the refunded debt. Admin. Rec. 273 (Langenfeld); J.A. 24 (Andrews). After an advance refunding transaction, the provider no longer carries costs of the refunded debt on its financial records. J.A. 14-15 (Huelskamp). Payments on the refunded debt are made by the trustee, not the hospital, and any costs are "incurred" by the trustee. J.A. 24-25 (Andrews). After the advance refunding transaction, the bond holders of the old bonds have no recourse against the provider. Admin. Rec. 235-36 (Huelskamp). For the purposes of the hospital, the old debt has "ceased to exist" after the defeasance. Admin. Rec. 263 (Langenfeld).

As shown by the testimony of Mr. Langenfeld of Ernst & Whinney, the loss on defeasance, if it relates to any year other than the year of the defeasance transaction, would relate to past periods, not future periods. J.A.

20-21, 23; Admin. Rec. 306. The loss is simply a recognition of the difference between the net carrying costs of the old bonds and the price necessary to reacquire the bonds. Admin. Rec. 256, 262, 267-68. In other words, the loss occurred because, due to declining interest rates, the cost of reacquiring the bonds increased compared to the value at which the bonds were carried on the hospital's books. That loss would occur regardless of whether any new debt, extending into future years, had been contemporaneously issued. Admin. Rec. 265-67 (Langenfeld).

Because the outcome of the instant case may control the outcome of the *Mother Frances* and *Osteopathic Medical Center* cases filed by the Amici Hospitals, it should be noted that Mr. Langenfeld's testimony also formed part of the stipulated administrative record in those two cases. In addition, the record in those two cases included testimony from two other expert witnesses on behalf of the providers. It did not include Ms. Andrews' testimony, but instead the testimony on behalf of the Medicare fiscal intermediary was furnished by Mr. Wilson Leong.[9]

In the *Mother Frances* and *Osteopathic Medical Center* cases, Mr. Leong attempted to support the Administrator's "economic reality" argument by proffering the view that "the actuality of the situation is that the debt has not been liquidated." This exchange then occurred:

Question:	The actuality of the situation?
Answer:	The factual matter is bond holders have not received the payments.

[9] Mr. Leong originally testified in the *St. John's* case, cited in nn. 7 and 8, above.

Question: Where in the Medicare regulations is there support for this perspective that you are now imposing? This actuality theory?

Answer: *In regulation, we don't have any.*

Administrative Record of *Mother Frances* case at 672 (filed as part of Record Excerpts in Fifth Circuit) (emphasis added)

No witness testified in the instant case as to any hospitals dropping out of the Medicare program,[10] or provided any testimony that Medicare utilization was likely to decrease in future years. The record is thus devoid of any support for the Administrator's "cross-subsidization" theory. It is the purest form of speculation.

Even if it were accepted that the loss on defeasance relates to patient care in the future (which it does not), and that Medicare utilization is likely to decrease rather than increase (a highly unlikely assumption given the aging of the population), it is virtually impossible that cross-subsidization of non-Medicare patients by Medicare would occur. The Congressional Budget Office ("CBO") and the Prospective Payment Assessment Commission ("PROPAC") estimate that in 1991 Medicare payments covered only 88 percent of the costs that hospitals incurred in treating Medicare patients, and that the total payments that hospitals received for treating Medicaid patients equalled approximately 82 percent of the costs

[10] As the Secretary is undoubtedly aware, few if any hospitals would consider dropping out of the Medicare program. Despite the history of Medicare underpayment, the program usually provides a large percentage of hospital revenues. In the case at bar, the testimony showed that Guernsey Memorial Hospital's Medicare utilization rate was approximately 67%. Admin. Rec. 187 (Huelskamp).

hospitals incurred in treating Medicaid patients.[11] The CBO and PROPAC agree that Medicare and Medicaid underreimbursed hospitals by $15.1 billion in 1991. Both the CBO and PROPAC studies recognize that hospitals use payments from privately insured patients to cover costs that are not fully reimbursed by Medicare and Medicaid. Cross-subsidization thus certainly occurs. But it is massively in the direction of private payors subsidizing Medicare, not the other way around.

It is to prevent agencies from issuing edicts based on nothing more than unsupported speculation that both the rulemaking and "substantial evidence" procedural safeguards were adopted by the APA. In formulating rules for future application, the agency must proceed by a publicly accountable, quasi-political process of substantive rulemaking. In adjudications conducted without benefit of a substantive, binding rule, it must support its decisions by substantial evidence. Here the agency has done neither.

[11] Congressional Budget Office Paper, "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals 'Cost Shift'?" (May 1993); Prospective Payment Assessment Commission, "Medicare and the American Health Care System, Report to Congress" (June 1993). The CBO was established pursuant to the Congressional Budget Act of 1974. PROPAC is appointed by the Director of the Congressional Office of Technology Assessment pursuant to 42 U.S.C. § 1395ww(e)(2)(A). Copies of these public documents will be furnished to the Court on request.

CONCLUSION

For the reasons stated above, the decision of the Sixth Circuit Court of Appeals should be affirmed.

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